DHS/DD/FS 700

FAMILY SUPPORT 360
APPLICATION
(Please Print)

_____ _____

APPLICANT'S NAME **GUARDIAN/FAMILY MEMBER (as needed)**

_____

APPLICANT'S ADDRESS

_____ _____ _____

CITY **STATE** **ZIP CODE**

_____ _____ _____

HOME/CELL PHONE **WORK PHONE** **SOCIAL SECURITY NUMBER**

_____ _____ _____

DATE OF BIRTH **MEDICAID NUMBER** **MALE/FEMALE**

_____

DEVELOPMENTAL DISABILITY DIAGNOSIS (Documentation of diagnosis is required). Please attach a copy of the most recent psychological evaluation, Individual Education Plan (IEP) or any other documentation with diagnostic information. If documentation of the diagnosis is not available, a release of information form will be required to access the information.

Does the applicant receive any of the following benefits/services?

_____SS _____Community Support Provider

_____SSI/SSDI _____Vocational Rehabilitation

_____Independent Living Services _____School services/IEP

_____Adult Services and Aging/Department of Social Services

_____Other (please describe) _____

Does the applicant live in a family member's home on a full time basis? _____ (yes/no)

Does the applicant live in their own home in his/her community? _____ (yes/no)

Who referred you? _____

I understand to be eligible for the Family Support 360 Program the applicant must be diagnosed with a developmental disability prior to the age of 22 and live in a family member's home or their own home.

_____

APPLICANT'S SIGNATURE **DATE**

_____

GUARDIAN SIGNATURE (if applicable) **DATE**

Additional information regarding Family Support 360 may be found at http://dhs.sd.gov/dd/family/index.aspx